STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/17/23 through 07/20/23. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID# 6TV011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/17/23 through 07/20/23. Event ID# 6TV011. The following intakes were investigated: NC00200576 and NC00192576. None of the 11 complaint allegations resulted in a deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 582		8/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/11/2023

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F 582	Continued From page 1 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide completed Notice of Medicare Non-Coverage (NOMNC) and/or Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF-ABN) to 3 of 3 residents reviewed for Beneficiary Notification (Residents #102, #103, and #104).	F 582	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of	

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F 582	Continued From page 2 Findings included: A review of the Beneficiary Notice Worksheet provided by the Administrator on 07/17/23 revealed the following residents were discharged from Medicare Part A skilled services during the previous six months: a. Resident #102 was admitted to the facility on 02/01/23 and discharged to the community on 02/24/23. Review of Resident #102's medical record revealed no evidence a NOMNC or SNF-ABN was provided to Resident #102 when her Medicare Part A skilled services ended. b. Resident #103 was admitted to the facility on 03/01/23 and discharged to the community on 03/18/23. Review of Resident #103's medical record revealed no evidence a NOMNC or SNF-ABN was provided to Resident #103 when her Medicare Part A skilled services ended. c. Resident #104 was admitted to the facility on 04/10/23 and discharged to the community on 05/30/23. Review of Resident #104's medical record revealed no evidence a NOMNC or SNF-ABN was provided to Resident #104 when her Medicare Part A skilled services ended. During interviews on 07/18/23 at 5:20 PM and 07/20/23 at 2:00 PM, the Administrator revealed the previous Bookkeeper was responsible for	F 582	residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 582 On 7/18/23, the Administrator completed an audit of NOMNC's (Notice of Medicare Non-Coverage) for the past 6 months. Findings noted that resident #102, resident #103 and resident #104 did not receive a NOMNC's (Notice of Medicare Non-Coverage) per facility policy. On 7/18/23, the Administrator initiated a Plan of Correction due to the findings of the audit completed on 7/18/23. On 7/18/23, the Administrator initiated an in-service to the Social Worker and Medical Records Clerk regarding the facility's policy of the NOMNC's (Notice of Medicare Non-Coverage) by utilizing the guide to Medicare Beneficiary Notices Initiative, which explains to whom and when to provide notices for Medicare Beneficiaries when changes occur. On 7/18/23, the Administrator instructed the Social Worker and Medical Records	

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F 582	Continued From page 3 completing the NOMNCs and/or SNF-ABN forms when a resident's Medicare Part A skilled services ended. The Administrator stated they had looked everywhere for the copies of the NOMNCs and SNF-ABNs that were completed; however, they were unable to locate any documentation for the resident's listed on the Beneficiary Notice worksheet she had provided. The Administrator explained when the previous Bookkeeper retired in July 2023, she had packed up her office and they had looked through the boxes she had placed in storage but were unable to find any documentation of the completed NOMNC or SNF-ABNs for Resident #102, Resident #103, or Resident #104. The Administrator stated the previous Bookkeeper came to the facility to try and locate the documents, even looking through the recycle bin in case she had accidentally thrown them away, but she was unable to locate the NOMNCs or SNF-ABNs she had completed. The Administrator stated the previous Bookkeeper informed her she had completed the NOMNCs and SNF-ABNs but since they were unable to locate any of the documents, she could not state for sure if they had been completed as they should have been.	F 582	Clerk to complete the NOMNC (Notice of Medicare Non-Coverage) facility training video via Relias. The Social Worker and Medical Records Clerk completed this video training on 7/18/23. When an admission comes into the facility under Medicare part A benefits, the Social Worker or Medical Records Clerk (in her absence) must give the NOMNC (Notice of Medicare Non-Coverage) 48 hours prior to end of services. The Social Worker or Medical Records Clerk (in her absence), will ensure this is being completed as deemed needed for each Medicare part A resident. Discharges are discussed in Interdisciplinary Team (IDT) Meeting and the NOMNC (Notice of Medicare Non-Coverage) will be initiated 48 hours prior to the patient's planned discharge date whether leaving the facility and/or remaining in the facility. The Social Worker will audit the NOMNC's (Notice of Medicare Non-Coverage) weekly for three months ensuring compliance and review the audit with the Administrator. The Social Worker will bring audit findings to the monthly Quality Assurance and Performance Improvement meeting to review any deficient practice and to show compliance with resolution of any deficient practice for three months and as needed. The completion date for the plan of correction is 8/11/2023.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		8/11/23

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F 584	Continued From page 4	F 584		

The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.

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F 584	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to secure a loose metal plate and place a cover over the telephone jack leaving the cutout in the wall and the metal plate exposed (room 39-A), failed to repair areas of missing and discolored caulk and replace floor tiles with a buildup of a black colored substance around the base of the toilet in a shared bathroom (rooms 33 and 34) with odors resembling urine and failed to secure the light fixture located over the head of the bed (room 9-B) for 4 of 4 rooms on 2 of 2 halls reviewed for environment. The findings included: 1. During an observation on 07/17/23 at 1:55 PM the cutout for the telephone jack located on the lower portion of the wall behind the head of the bed in room 39-A had a loose-fitting metal plate with pointed edges and no cover to enclose the cut area of the sheetrock of the telephone jack. 2. During observations on 07/17/23 at 11:26 AM and 07/18/23 at 2:39 PM the shared bathroom of rooms 33 and 34 had an odor resembling urine. At the base of the toilet there were areas with missing or black stained caulking. The floor tiles surrounding the base of the toilet had a buildup of a black colored substance. The bathroom appeared clean, and the floor was dry. An observation and interview were conducted with the Maintenance Director on 07/20/23 from 12:40 PM through 12:53 PM. Rooms 9-B, 33, 34, and 39-A were observed to be in the same condition with no sign repairs were being made. The Maintenance Director stated the lose metal	F 584	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 584 On 7/20/2023, the Maintenance Director secured the loose metal plate and placed a cover over the telephone jack in room 39A. The Maintenance Director replaced caulk around the toilet in rooms 33 and 34 and secured the light fixture located over the head of bed for room 9B. On 7/20/2023, the Floor Technician and Housekeeping Supervisor cleaned and removed black colored substance around toilet and on floor tiles in bathroom of rooms 33 and 34.	

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F 584	Continued From page 6 plate exposing the telephone jack in room 39-A was not connected to any electrical source but should be tightened and have a cover to prevent a resident from possible injury from the loose plate. The Maintenance Director revealed the light fixture over the bed in room 9-B was not fully secured to the wall and should be tightened to prevent it from falling. The Maintenance Director observed the shared bathroom of rooms 33 and 34 and stated both the floor tiles and caulk need replaced and should help prevent the urine like odors. The Maintenance Director revealed he checked resident rooms approximately once a month for environment concerns and staff use the computer system (TELS) to inform him of any environment concerns and stated he was not aware of the issues observed in rooms 9-B, 33, 34, and 39-A. An interview was conducted on 07/20/23 at 2:10 PM with the Administrator. The Administrator revealed staff report environment concerns to the Maintenance Director using the computer system (TELS). The Administrator revealed the loose metal plate and missing cover, and loose light fixture should be secure to prevent injury. The Administrator revealed staff should notice issues observed in rooms 33, 34, and 39-A and report and notify the Maintenance Director so they could be fixed. 3. Observations of room 9-B on 07/17/23 at 11:54 AM revealed the metal light fixture over the head of the bed was loose and not fully secured to the wall. Subsequent observations on 07/18/23 at 3:32 PM, 07/19/23 at 12:01 PM, and 07/20/23 at 9:36 AM revealed the condition of the light fixture over	F 584	On 7/20/2023, an in-service was initiated by the Administrator for the Maintenance Director regarding issues with residents rooms and work orders must be addressed when brought to his attention. Over bed lights must be secured properly, Phone jacks must be secured properly and residents toilets and flooring in residents bathrooms kept in good condition. On 7/26/2023, the Administrator initiated an in-service for facility staff educating them on notifying the Maintenance Director, or Administrator in his Absence, regarding Maintenance/Environmental issues via Direct Supply TELs Work Order system utilizing Point Click Care. This in-service was completed on 8/11/23 for all facility staff by in-person in-servicing or by mail. If the in-service was mailed, the staff members must complete one on one education by the Staff Development Coordinator prior to next scheduled shift. On 7/26/2023, the Administrator began auditing resident rooms and bathrooms to ensure that rooms were free of Maintenance/Environmental issues. Any issues found where assigned to Maintenance Director via the Direct Supply TELs system via Point Click Care. Ten percent of resident rooms and bathrooms will be audited three times per week for three months. All findings will be presented to the Quality Assurance and Performance Improvement team by the Administrator or Director of Nursing, for review and recommendations for three months and as needed.	

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F 584	Continued From page 7 the head of the bed remained unchanged. An observation and interview were conducted with the Maintenance Director on 07/20/23 from 12:40 PM through 12:53 PM. The light fixture over the head of the bed in room 9-B was observed to be in the same condition with no sign repairs were being made. The Maintenance Director stated the light fixture over the bed in room 9-B was not fully secured to the wall and should be tightened to prevent it from falling. The Maintenance Director revealed he checked resident rooms approximately once a month for environment concerns and staff used the computer system (TELS) to inform him of any environment concerns. The Maintenance Director stated he was not aware of the issue with the light fixture being loose in room 9-B. An interview was conducted on 07/20/23 at 2:10 PM with the Administrator. The Administrator explained staff reported environment concerns to the Maintenance Director using the computer system (TELS). The Administrator stated the loose metal light fixture in room 9-B should be secured to the wall to prevent injury. The Administrator stated staff should have noticed the light fixture in room 9-B and notified the Maintenance Director so it could be fixed.	F 584	The completion date for the plan of correction is 8/11/2023.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 641	Graham Healthcare & Rehabilitation	8/11/23

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F 641	Continued From page 8 facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of hospice and tobacco use for 2 of 3 sampled residents reviewed for hospice and smoking (Residents #47 and #22). Findings included: 1. Resident #47 was admitted to the facility on 06/29/23. The Hospice Plan of Care, with an effective date of 06/29/23, revealed Resident #47 was certified to receive hospice services for end of life care. The admission Minimum Data Set (MDS) assessment dated 07/05/23 revealed Resident #47 had a life expectancy of 6 month or less; however, hospice care was not marked as received under special services and treatments. During an interview on 07/20/23 at 10:34 AM, MDS Nurse #1 confirmed Resident #47 was admitted to the facility under hospice care. She stated the MDS assessment dated 07/05/23 did not accurately reflect he received hospice care and it was an oversight. During an interview on 07/20/23 at 2:00 PM, the Administrator stated MDS assessments should be completed accurately per the Resident Assessment Instrument (RAI) guidelines (manual that explains how to code items on the MDS assessment). 2. Resident #22 was admitted to the facility on 02/17/21. Review of Resident #22's comprehensive care	F 641	acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 641 On 7/20/2023, resident #47 Minimum data Set (MDS) Admission assessment with ARD of 7/05/2023 was modified to accurately code resident # 47 life expectancy of 6 months or less/hospice care status by the MDS Coordinator. On 7/20/2023, resident #22 Minimum Data Set (MDS) Admission assessment with ARD of 12/10/2022 was modified to accurately code resident # 22 resident's current tobacco use status by the MDS Coordinator. On 7/20/2023 the modified assessments were submitted and accepted by the National Repository.	

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F 641	Continued From page 9 plans, initiated 03/05/21 and last revised 07/17/23, revealed a plan that addressed a problem area of inappropriate smoking or use of tobacco/tobacco substitute products related to decreased safety awareness and risk for potential injury to self. Interventions included for staff to evaluate Resident #22's ability to smoke safely on a consistent and regular basis and supervise her smoking and monitor her extinguishing a cigarette. A Smoking Assessment dated 12/08/22 revealed Resident #22 was assessed as a supervised smoker. The admission Minimum Data Set (MDS) assessment dated 12/10/22 for Resident #22 revealed current tobacco use was marked as "no". During an interview of 07/20/23 at 10:34 AM, MDS Nurse #1 confirmed Resident #22 was a supervised smoker. She stated the MDS assessment dated 12/10/22 did not accurately reflect she used tobacco and it was an oversight. During an interview on 07/20/23 at 2:00 PM, the Administrator stated MDS assessments should be completed accurately per the Resident Assessment Instrument (RAI) guidelines (manual that explains how to code items on the MDS assessment).	F 641	On 7/20/2023, the MDS Coordinator began auditing each resident on hospice care and current tobacco use last assessment to ensure hospice care and tobacco use are coded accurately. Audit was completed on 7/20/2023. Assessments will be modified for accuracy of coding as necessary. On 7/20/2023, the MDS Coordinator, was in-serviced by the Administrator on correctly coding section J (Health Conditions), Section O (Special Treatments, Procedures, and Programs) per the Resident Assessment Instrument (RAI) Manual. On 7/20/2023, the MDS Coordinator or Administrator, began auditing MDS assessments for correct resident hospice care and tobacco use coding using the MDS Accuracy Audit Tool. All residents receiving hospice care and current tobacco use will be audited using the MDS Accuracy Audit Tool to ensure MDS assessment accuracy three times per week for twelve weeks. All findings will be presented to the Quality Assurance and Performance Improvement team by the Administrator or Director of Nursing, for review and recommendations for three months and as needed. The completion date for the plan of correction is 8/11/2023.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		8/11/23

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F 656	Continued From page 10	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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F 656	Continued From page 11 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan that addressed hospice care for 1 of 1 sampled resident reviewed for hospice (Resident #47). Findings included: Resident #47 was admitted to the facility on 06/29/23 with diagnoses that included congestive heart failure and malignant neoplasm of colon. The Hospice Plan of Care, with an effective date of 06/29/23, revealed Resident #47 was certified to receive hospice services for end of life care. Review of Resident #47's medical record revealed a physician's order dated 06/30/23 for hospice services. The admission Minimum Data Set (MDS) assessment dated 07/05/23 revealed Resident #47 had a life expectancy of 6 month or less; however, hospice care was not marked as received under special services and treatments. Review of Resident #47's comprehensive care plans, last revised 07/17/23, revealed no care plan for hospice services. During an interview on 07/20/23 at 10:34 AM, MDS Nurse #1 confirmed Resident #47 was admitted to the facility under hospice care. She	F 656	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 656 On 7/20/2023, the Minimum Data Set Coordinator updated Resident #47's care plan to include hospice care for the resident. On 7/20/2023, the Minimum Data Set Coordinator performed an audit of every resident receiving hospice care for care	

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F 656	Continued From page 12 stated a hospice care plan should have been developed and was overlooked. During an interview on 07/20/23 at 2:00 PM, the Administrator stated Resident #47 was admitted to the facility under hospice care and a care plan should have been initiated upon his admission.	F 656	plan for accuracy. No additional issues were identified. On 7/20/2023, the Minimum Data Set Coordinator was in-serviced by the Administrator to develop, implement, and update residents comprehensive person-centered care plans for each resident according to the needs that are identified in the comprehensive assessment. On 7/24/2023, the Administrator assigned the Principle Baseline Care Plan Module via Relias for facility nurses. This training was completed by each nurse via Relias on 8/21/2023. All newly hired facility nurses will be educated and trained regarding developing, implementing and updating resident's comprehensive person-centered care plans during new employee orientation. On 7/26/2023, the Staff Development Coordinator initiated an in-service for all facility nurses that each resident must have a baseline comprehensive person-centered care plan that is developed, implemented, and updated on admission according to the resident's needs and updated as needed. This in-service was completed on 8/08/23 for all nurses by in-person in-servicing or by mail. If the in-service was mailed, the staff members must complete one on one education by the Staff Development Coordinator prior to next scheduled shift. All newly hired nurses will be educated and trained regarding developing, implementing, and updating resident's comprehensive person-centered care plans during new employee orientation via	

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F 656	Continued From page 13	F 656	Relias training. Beginning 7/21/2023, the Minimum Data Set Coordinator or Administrator will audit resident's comprehensive person-centered care plans who are receiving hospice services by using the Care Plan Audit Tool, to ensure care plan accuracy three times per week for twelve weeks. All findings will be presented to the Quality Assurance and Performance Improvement team by the Administrator or Director of Nursing, for review and recommendations for three months and as needed. The completion date for the plan of correction is 8/11/2023.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective	F 867		8/11/23

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F 867	Continued From page 14	F 867		

systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

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(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and

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F 867	Continued From page 16 assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following a recertification and complaint investigation survey completed on 12/02/21. This failure was for one deficiency originally cited in the area of Develop/Implement Comprehensive Care Plan that was subsequently recited during a recertification and complaint investigation completed 07/20/23. This continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA Program. The findings included: This tag is cross referenced to: F656: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan that addressed hospice care for 1 of 1 sampled resident reviewed for	F 867	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

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F 867	Continued From page 17 hospice (Resident #47). During the recertification and complaint investigation survey of 12/02/21, the facility failed to develop care plans that addressed a resident's diabetes and anticoagulant (blood thinner) medication use. During an interview on 07/20/23 at 2:19 PM, the Administrator revealed the concerns identified during the recertification survey of 2021 were reviewed by the QAPI committee and the processes that were put into place to ensure compliance had been effective at the time. The Administrator stated the previous Minimum Data Set (MDS) Coordinator resigned in August 2022 and the current MDS Coordinator was still new to the position. She explained there was a lot to learn related to the MDS assessment process and felt that the repeat concern related to care plans not being developed was just an oversight.	F 867	F 867 On 7/20/23, the Minimum Data Set Coordinator (MDS) updated the care plan for resident #47 regarding hospice care. On 7/20/23, the Minimum Data Set Coordinator (MDS) completed a 100% care plan audit of all resident's receiving hospice care. No further issues were identified. On 7/20/2023, the Minimum Data Set Coordinator was in-serviced by the Administrator to develop, implement and update residents comprehensive person-centered care plans for each resident according to the needs that are identified in the comprehensive assessment. On 7/24/2023, the Administrator assigned the Principle Baseline Care Plan Module via Relias for facility nurses. This training was completed by each nurse via Relias on 8/21/2023. All newly hired facility nurses will be educated and trained regarding developing, implementing and updating resident's comprehensive person-centered care plans during new employee orientation. On 7/26/2023, the Staff Development Coordinator initiated an in-service for all facility nurses that each resident must have a baseline comprehensive person-centered care plan that is developed, implemented, and updated on admission according to the residents needs and updated as needed. This in-service was completed on 8/08/23 for all nurses by in-person in-servicing or by mail. If the in-service was mailed, the staff members must complete one on one	

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F 867	Continued From page 18	F 867	education by the Staff Development Coordinator prior to next scheduled shift. All newly hired nurses will be educated and trained regarding developing, implementing, and updating residents comprehensive person-centered care plans during new employee orientation via Relias training. On 7/27/2023 the Corporate Clinical Consultant initiated an in-service for the Quality Assurance Performance Improvement (QAPI) Committee on the process of the QAPI program. Beginning 7/21/2023, the Minimum Data Set Coordinator or Administrator will audit resident's comprehensive person-centered care plans who are receiving hospice services by using the Care Plan Audit Tool to ensure care plan accuracy three times per week for twelve weeks. The Facility Consultant/Corporate Clinical Director will attend the facility Quality Assurance Performance Improvement (QAPI) monthly meetings to ensure the facility is following the Regulatory and Corporate Policy for QAPI. The Facility Consultant/Corporate Clinical Director will review the minutes and the Performance Improvement Plans once a month for three months. The Administrator will hold monthly Quality Assurance Performance Improvement Committee (QAPI) meetings with the QAPI committee and the meeting agenda will include the review of all Performance Improvement Plans (PIP) and will include the PIP for Comprehensive Person-Centered Care	

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F 867	Continued From page 19	F 867	Plans. The Care Plan Audit Tool will be reviewed monthly for three months to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The completion date for the plan of correction is 8/11/2023.	